STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 00 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN47720

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F0000	This visit was for the Investigation of Complaint IN00090882. This visit included the Post-Survey Revisit (PSR) to the Investigation of Complaint IN00088724 completed on April 14, 2011. This visit included the PSR to the Investigation of Complaints IN00089836, IN00089626, and IN00089748 completed on May 5, 2011. Complaint IN00090882- Substantiated, Federal/State deficiencies are cited at F282 and F323. Survey dates: June 13, 14, 15, and 16, 2011 Facility number: 000442 Provider number: 155621 AIM number: 100266510 Survey team: Anne Marie Crays, RN-TC Census bed type: SNF: 38 SNF/NF: 61 Total: 99	F0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 29, 2011 to the complaint survey conducted on June 16, 2011. We respectfully request that you review this information, request any further information you may require, and then consider a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census payor type: Medicare: 20 Medicaid: 45 Other: 34 Total: 99 Sample: 8 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 20, 2011 by Bev Faulkner, RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure a lap tray utilized for positioning was placed on a wheelchair as ordered by the physician,	F0282	**F282 It is the practice of Pine Haven Health and Rehabilitation Center to assure that the residents' care plans**	06/29/2011

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	for 1 of 4 residents reviewed for falls, in a sample of 8. Resident A Findings include: The clinical record of Resident A was reviewed on 6/13/11 at 11:20 A.M. Diagnoses included, but were not limited to, Dementia, Parkinson's disease, and Epilepsy. A Physician's order, dated 4/15/11, indicated, "...May use deluxe tray [with] quick release clamps to w/c to aide [sic] in positioning due to poor posture." A Care Plan, initially dated 5/23/09 and updated 4/15/11, indicated a problem of "Potential for falls R/T [related to]: Attempts to stand unassisted. History of previous falls. Loses balance easily. Unsteady gait...." The Interventions included: "4/15/11 Deluxe tray [with] Quick release clamps to w/c to aide [sic] in positioning d/t [due to] poor posture." Nurse's Notes, dated 4/25/11 at 2:35 A.M., indicated, "Gotten up in w/c in TV lounge. Heard noise resident had fallen out of w/c. Has laceration to forehead [approximately] 3 cm [centimeters] length, width linear 0.1 cm edges approximated [and] steri striped [sic] [after] cleansing...Small am't [amount]		**are followed appropriately in accordance with the assessed needs.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident #A is no longer a resident of the facility. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that they are receiving services in accordance with the plan of care. The CNA assignment sheets appropriately address residents' needs based on the assessment and a monitoring system has been implemented to assure that interventions are appropriately in place. ***The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:*** The interdisciplinary team will be reviewing every fall to assure that appropriate interventions are in place based on the possible cause of the fall. The plan of care and the CNA assignment sheets will be updated as needed. The nursing staff has again been in-serviced related to providing services to our residents in correlation with the written plan of care. In addition, there will be additional emphasis for new CNA's related to reviewing their assignment sheets so that they are aware of the plan of care established for the resident. There will be routine	

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	bleeding from nose...Has red bruise area [approximately] 2 cm diameter on [right] knee...." On 6/13/11 at 12:15 P.M., the ADON (Assistant Director of Nursing) provided an "Incident/Accident Report," dated 4/25/11. The report included: "...Resident attempting to get up unassisted several times wanting to get up...resident gotten up per CNA in w/c, placed in TV lounge...Heard noise, resident on floor, w/c in normal position...Additional comments and/or steps taken to prevent recurrence: Education to new staff importance of CNA assignment sheet to keep on @ all times...." During interview at that time, the ADON indicated he was not employed by the facility on 4/25/11, and did not have additional information. On 6/16/11 at 6:25 A.M., during interview with RN # 1, she indicated she was the nurse working when Resident A fell on 4/25/11. RN # 1 indicated a "new CNA" transferred the resident to a wheelchair, and did not place the lap tray on the wheelchair as ordered. This federal tag relates to Complaint IN00090882. This deficiency was cited on 4/14/11. The facility failed to implement a systemic		monitoring via rounds by nurses and nursing administration to assure that safety devices are in place and functional in accordance with the residents' plans of care. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents' comprehensive assessment in correlation with the plan of care to assure that the pertinent information based on the assessment is accurately communicated and being followed in accordance with the residents' identified needs. Safety device placement and function will be specifically identified on the monitoring form. Nursing Administration, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** 6-29-11	

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	plan of correction to prevent recurrence. 3.1-35(g)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a lap tray utilized for positioning was placed on a wheelchair, causing the resident to fall and obtain a laceration on her forehead, for 1 of 4 residents reviewed for falls, in a sample of 8. Resident A Findings include: The clinical record of Resident A was reviewed on 6/13/11 at 11:20 A.M. Diagnoses included, but were not limited to, Dementia, Parkinson's disease, and Epilepsy. An annual Minimum Data Set [MDS] assessment, dated 3/19/11, indicated Resident A had a short-term and long-term memory problem, was moderately impaired in cognitive skills for daily decision-making, was non-ambulatory, and required extensive assistance of one staff for transfer. A Physician's order, dated 3/31/11, indicated, "OT [occupational therapy] eval [evaluation] only for evaluation of improvent [sic] of positioning in w/c [wheelchair] (extreme leaning forward)."	F0323	**F323 It is the practice of Pine Haven Health and Rehabilitation Center to assure that the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistance devices to prevent accidents.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident #A no longer resides at the facility. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that they are receiving services in accordance with the plan of care and assessed safety devices. The CNA assignment sheets appropriately address residents' needs based on the assessment and a monitoring system has been implemented to assure that interventions are appropriately in place. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The interdisciplinary team will be reviewing every fall to assure that appropriate interventions are in place based on the possible	06/29/2011

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	An OT note, dated 4/1/11, indicated, "...Reason for Referral:...multiple medical complexities affecting positioning in wheelchair, general weakness and postural fatigue requiring OT intervention due to severe leaning and decreased safety in wheelchair...." A Physician's order, dated 4/15/11, indicated, "...May use deluxe tray [with] quick release clamps to w/c to aide [sic] in positioning due to poor posture." A Care Plan, initially dated 5/23/09 and updated 4/15/11, indicated a problem of "Potential for falls R/T [related to]: Attempts to stand unassisted. History of previous falls. Loses balance easily. Unsteady gait...." The Interventions included: "4/15/11 Deluxe tray [with] Quick release clamps to w/c to aide [sic] in positioning d/t [due to] poor posture." Nurse's Notes, dated 4/25/11 at 2:35 A.M., indicated, "Gotten up in w/c in TV lounge. Heard noise resident had fallen out of w/c. Has laceration to forehead [approximately] 3 cm [centimeters] length, width linear 0.1 cm edges approximated [and] steri striped [sic] [after] cleansing...Small am't [amount] bleeding from nose...Has red bruise area [approximately] 2 cm diameter on [right]		cause of the fall. The plan of care and the CNA assignment sheets will be updated as needed. The nursing staff has again been in-serviced related to providing services to our residents in correlation with the written plan of care. In addition, there will be additional emphasis for new CNA's related to reviewing their assignment sheets so that they are aware of the plan of care established for the resident. There will be routine monitoring via rounds by nurses and nursing administration to assure that safety devices are in place and functional in accordance with the residents' plans of care. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents' comprehensive assessments in correlation with the plans of care to assure that the pertinent information based on the assessments is accurately communicated and being followed in accordance with the residents' identified needs. Safety device placement and function will be specifically identified on the monitoring form. Nursing Administration, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will	

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	knee...Denies pain except to head [and] nose...Assisted back into w/c by staff x [two]." The resident was transferred to the hospital on 4/25/11 at 4:00 A.M., and returned the same day at 7:10 A.M., with the steri strips left in place on the resident's forehead. On 6/13/11 at 12:15 P.M., the ADON (Assistant Director of Nursing) provided an "Incident/Accident Report," dated 4/25/11. The report included: "...Resident attempting to get up unassisted several times wanting to get up...resident gotten up per CNA in w/c, placed in TV lounge...Heard noise, resident on floor, w/c in normal position...Additional comments and/or steps taken to prevent recurrence: Education to new staff importance of CNA assignment sheet to keep on @ all times...." During interview at that time, the ADON indicated he was not employed by the facility on 4/25/11, and did not have additional information. On 6/16/11 at 6:25 A.M., during interview with RN # 1, she indicated she was the nurse working when Resident A fell on 4/25/11. RN # 1 indicated a "new CNA" transferred the resident to a wheelchair, and did not place the lap tray on the wheelchair as ordered.		be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** 6-29-11	

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	On 6/15/11 at 10:45 A.M., the Assistant Director of Nursing [ADON] provided the current facility policy on "Falls Prevention," dated 9/08. The policy included: "Policy, To ensure that residents are safe and that appropriate preventive measures are initiated to minimize injuries related to falls...." This federal tag relates to Complaint IN00090882. This deficiency was cited on 4/14/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-45(a)(2)			

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